

School Name & Address:

Grade: _____



STATE OF RHODE ISLAND SCHOOL PHYSICAL FORM

Health Care Provider Name and Address:

Phone: _____

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last	First	Middle	Date of Birth	Sex
Address: Street	Apt #	City	State	Zip Code
			Home Phone	

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

IMMUNIZATIONS					
Please enter dates in MM/DD/YYYY format					
Hepatitis B					
Diphtheria-Tetanus-Pertussis DTaP < 7 years					
Pneumococcal Conjugate PCV					
Polio					
Haemophilus Influenzae Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella					
	<input type="checkbox"/> Student has history of varicella disease				
Tetanus-Diphtheria-Pertussis Td/Td > 7 years					
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					
Influenza					

Medical Exemption:

☐ Hep B
 ☐ DTaP
 ☐ PCV
 ☐ Polio
 ☐ Hib
 ☐ MMR
 ☐ Varicella
 ☐ Td/Tdap
 ☐ Rotavirus
 ☐ Hep A
 ☐ Mening
 ☐ HPV
 ☐ Influenza

PHYSICAL EXAMINATION

Date of PE ____/____/____ Height _____ Weight _____ BP _____

PLEASE NOTE ANY HEALTH PROBLEM, CHRONIC HEALTH CONDITION OR DISABILITY THAT MAY AFFECT BEHAVIOR OR HEALTH AT SCHOOL:

- ASTHMA: No ☐ Yes ☐ If yes, complete an Asthma Action Plan (www.health.ri.gov/publications/actionplans/2012Asthma.pdf)
- ALLERGIES: No ☐ Yes ☐ (Please explain) _____ EPINEPHRINE AUTO-INJECTOR REQUIRED: No ☐ Yes ☐
If student has a severe allergy (food, insect, other) complete a Food Allergy & Anaphylaxis Emergency Care Plan (www.foodallergy.org/document.doc?id=234)
- DIABETES: No ☐ Yes ☐ If yes, complete a Physicians Order Form For Students With Diabetes (www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf)
- OTHER: _____

Treatment Plan: _____

RESTRICTIONS: Can participate in physical education/sports: Fully ☐ With limitation ☐ _____

MEDICATION (REQUIRED AT SCHOOL): No ☐ Yes ☐ (Please list) _____

Other medication(s) that may affect behavior or health at school: _____

LEAD SCREENING (Required for children < 6 years old) Student is in compliance with lead screening requirements: Yes <input type="checkbox"/> No <input type="checkbox"/>	SCOLIOSIS SCREENING Yes <input type="checkbox"/> No <input type="checkbox"/>	VISION SCREENING (Children entering Kindergarten) <input type="checkbox"/> Passed Screening <input type="checkbox"/> Screened & referred for comprehensive exam <input type="checkbox"/> Referred for comprehensive exam, but not screened Screening / Referral Date: _____ Comprehensive Exam Date: _____
TUBERCULOSIS (If required by school district) Date of TB test: _____		

HEALTH CARE PROVIDER SIGNATURE: _____

DATE: _____

PRINT NAME: _____